

01 <input type="checkbox"/> Insured's GIC-ID (usually Soc. Sec. #)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /		Dept. ID # or Agency/Division # /	
Name - Last		First		MI			
Address <input type="checkbox"/> This is a new address				City		State	
Date Entered Service / /		Bargaining Unit/Union Name		HR/CMS or UMASS Employee ID #:		Home Phone ( )	
						Work Phone ( )	
02 <input type="checkbox"/> <b>LIFE, HEALTH AND LTD COVERAGE</b>						<b>Effective Date:</b> /01/	
New Enrollment: <input type="checkbox"/>		Change: <input type="checkbox"/>		<b>Cancel Coverage</b> <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Health Insurance <input type="checkbox"/> Optional Life Insurance			
<input type="checkbox"/> <b>Basic Life Only</b> <input type="checkbox"/> <b>Long Term Disability (LTD)</b> <input type="checkbox"/> <b>Basic Life and Health</b> (Select one of the Health Plans below)				Annual Salary: \$ _____ Salary Effective Date: ____/____/____			
<b>Health Plan</b> <input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (PPO) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO) <input type="checkbox"/> Health New England (HMO)				<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (PPO) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)			
				<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare/Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type)			
<b>Optional Life Please Check One:</b> <input type="checkbox"/> <b>Automatic Increase</b> Indicate Multiple Factor (1-8): _____ Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form. <input type="checkbox"/> <b>Non Automatic Increase</b> <b>Amount \$:</b> _____ No more than \$1000 less than annual salary rounded down to the nearest \$ 1,000				<input type="checkbox"/> <b>Automatic Increase – Family Status Change</b> Indicate Multiple Factor (1 – 4) _____ <input type="checkbox"/> <b>Non Automatic Increase – Family Status Change</b> <b>Amount \$:</b> _____ No more than \$1000 less than annual salary rounded down to the nearest \$1,000 <i>Marriage, divorce, birth/adoption, death of spouse. The GIC must receive documentation of family status change within 31 days of the event.</i>			
				<b>Please Check One:</b> <input type="checkbox"/> <b>Smoker</b> <input type="checkbox"/> <b>Non-Smoker</b> Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates			
03 <input type="checkbox"/> <b>Name Change</b>		Previous Name		New Name			
<b>LEAVE OF ABSENCE</b>						<b>FOR GIC USE ONLY:</b>	
04 <input type="checkbox"/> <b>Leave Is:</b> <input type="checkbox"/> With Pay <input type="checkbox"/> Without Pay Leave Type (You MUST Check one of the following): <input type="checkbox"/> Educational * <input type="checkbox"/> Maternity <input type="checkbox"/> Military Caregiver (26 weeks) <input type="checkbox"/> FMLA (12 weeks) <input type="checkbox"/> Personal Reason <input type="checkbox"/> * Personal Illness <input type="checkbox"/> Sabbatical <input type="checkbox"/> FMLA Military Exigency (12 weeks) <input type="checkbox"/> Family (for dep < age 3) <input type="checkbox"/> Other <input type="checkbox"/> * Industrial accident <input type="checkbox"/> Suspension <input type="checkbox"/> Military * Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.						<b>Effective Date:</b> /01/ Leave Pay Status: <input type="checkbox"/> Part <input type="checkbox"/> Full	
Duration of Leave:		Start Date / /		End Date / /		Last Day on Payroll / /	
05 <input type="checkbox"/> <b>Return to Payroll Deduction:</b>		First Day Back on Payroll / /		<b>FOR GIC USE ONLY:</b>		<b>Effective Date:</b> /01/	
<b>INSURED CHANGES</b>							
06 <input type="checkbox"/> <b>Retirement</b>		Date Retired / /		<input type="checkbox"/> ORP (Higher Ed Only) Fund Name:			
07 <input type="checkbox"/> <b>Transfer to another Agency</b>		Name of Agency Transferred to		Effective Date / /			
08 <input type="checkbox"/> <b>Transfer from another Agency</b>		Previous Agency		Effective Date / /			
09 <input type="checkbox"/> <b>Termination Coverage (if elected)</b>		Termination Reason		Termination Date ____/____/____ <input type="checkbox"/> 39 -Week Layoff Coverage <input type="checkbox"/> Deferred Retiree <input type="checkbox"/> COBRA (must complete COBRA application) <input type="checkbox"/> Conversion (contact carrier for application)			
<b>SIGNATURE REQUIRED</b> <b>Deduction Authorization:</b> I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected. <b>Long Term Disability Insurance (LTD):</b> I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability. <b>Health Insurance:</b> I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan. <b>Optional Life Insurance:</b> I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change. <b>At Retirement:</b> I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage. <b>Survivors:</b> I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage. <b>Termination:</b> I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect. • If you are applying for Health Insurance, be sure to file a Form IDF to list family members.							
x _____		Date		x _____		Date	
Signature of Applicant				Signature of Authorized Official		Date	
<b>FOR GIC USE ONLY:</b>		Entered		Verified		Political Subdivision	